

01

PERFORMANCE MEASURE

Type: Capacity

Category: Direct Health Care

The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with Special Health Care Needs (CSHCN) Program.

GOAL

For the State CSHCN program to provide rehabilitative services for blind and disabled children less than 16 years old receiving benefits under Title XVI, to the extent medical assistance for such services is not provided by Medicaid.

MEASURE

The percent of State SSI beneficiaries less than 16 years old who are receiving rehabilitative services from the State CSHCN program.

DEFINITION

Numerator:

The number of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State's CSHCN program during the Federal fiscal year.

Denominator:

The number of SSI beneficiaries less than 16 years old in the State.

Units: 100 **Text:** Percent

HEALTHY PEOPLE 2010 OBJECTIVE

Related to Objective 16-23

Increase the proportion of Territories and States that have service systems for Children with Special Health Care Needs to 100 percent. (Baseline: 15.7 percent of Territories and States met Title V for service systems for CSHCN in FY 1997).

DATA SOURCE and DATA ISSUES

State CSHCN and Medicaid programs and Federal Supplemental Security Income (SSI) program.

SIGNIFICANCE

Title V legislative requirements mandate the provision of rehabilitative services for blind and disabled individuals under the age of 16 receiving benefits under the SSI Program to the extent medical assistance for such services is not provided by Medicaid. The Title V responsibility for providing and promoting family-centered, community-based care serves as a basis for States to establish a policy whereby all SSI disabled children are eligible to participate in or benefit from the State Title V CSHCN Program.

PERFORMANCE MEASURE**Type:** Capacity**Category:** Direct Health Care

The degree to which the State Children with Special Health Care Needs (CSHCN) Program provides or pays for specialty and sub-specialty services, including care coordination, not otherwise accessible or affordable to its clients

GOAL

To provide and pay for services, including care coordination, for State specific sub-populations of CSHCN who are uninsured, under insured, or under served.

MEASURE

The State provides or pays for specialty and sub-specialty services not accessible or affordable for sub-populations of CSHCN within the State.

DEFINITION

Attached is a checklist of 9 specialty and sub-specialty services, provided or paid for, through State CSHCN Programs. Please check those provided for or paid by the CSHCN Program that were not otherwise accessible or affordable. Please keep the completed checklist attached. The answer is 0-9.

Numerator:

Denominator:

Units: 0-9 **Text:** Scale

**HEALTHY PEOPLE 2010
OBJECTIVE**

Related to Objective 16-23

Increase the proportion of Territories and States that have service systems for Children with Special Health Care Needs to 100 percent. (Baseline: 15.7 percent of Territories and States met Title V for service systems for CSHCN in FY 1997).

DATA SOURCE and DATA ISSUES

The State CSHCN Program.

SIGNIFICANCE

The State CSHCN programs have traditionally provided and/or financed specialty and sub-specialty care which is otherwise not accessible or available to sub-populations and has functioned as the payer of last resort for medical, habilitative and rehabilitative services, and equipment and assistive technology for segments of the CSHCN population. The legislation also mandates the direct involvement of State CSHCN programs in the design and implementation of care coordination programs and the actual provision of care coordination services, as determined by the States. This function is particularly critical given current changes in coverage resulting from managed care arrangements. SSI changes will, at least temporarily, cause many children to lose Medicaid benefits and other welfare reform measures, which are expected to increase these numbers.

PERFORMANCE MEASURE**Type: Capacity****Category: Enabling****The percent of Children with Special Health Care Needs (CSHCN) in the State who have a “medical/health home”****GOAL**

To have a "medical/health home" for all Children with Special Health Care Needs in the State.

MEASURE

The percent of Children with Special Health Care Needs who have a "medical/health home."

DEFINITION**Numerator:**

The number of children in the State with Special Health Care Needs* (CSHCN) who have a "medical/health home," during the Federal fiscal year.

Denominator:

The number of children in the State with Special Health Care Needs in the Federal fiscal year.

Units: 100 **Text:** Percent

**HEALTHY PEOPLE 2010
OBJECTIVE**

Objective 16-22 (Developmental):

Increase the proportion of CSHCN who have access to a medical home.

DATA SOURCE and DATA ISSUES

The State CSHCN program and the American Academy of Pediatrics (AAP). Available methods include NACHRI, QuICK (Stein, 1993), and NHIS (synthetic estimates).

SIGNIFICANCE

The MCHB uses the American Academy of Pediatrics (AAP) definition of “medical/health home.” The AAP believes that the medical care of infants, children, and adolescents ideally should be accessible, continuous, comprehensive, family centered, coordinated, and compassionate. It should be delivered or directed by well-trained physicians who are able to manage or facilitate essentially all aspects of pediatric care. The physician should be known to the child and family and should be able to develop a relationship of mutual responsibility and trust with them. These characteristics define the “medical/health home” and describe the care that has traditionally been provided by pediatricians in an office setting. In contrast, care provided through emergency departments, walk-in clinics, and other urgent -care facilities is often less effective and more costly. (American Academy of Pediatrics, Volume 90, Number 5, November 1992)

*Children with Special Health Care Needs - Those children who have or are at increased risk for chronic physical, developmental, behavioral, or emotional conditions and who require health and related services of a type or amount beyond that required by children generally. Include children from birth to 21 years old.

PERFORMANCE MEASURE**Type: Risk Factor****Category: Population Based**

Percent of newborns in the State with at least one screening for each of PKU, hypothyroidism, galactosemia, hemoglobinopathies [(e.g. the sickle cell disease) (combined)].

GOAL

To ensure that all newborns with preventable mental retardation and other non-reversible consequences of selected genetic disorders (PKU, congenital hypothyroidism, galactosemia and hemoglobinopathies) are identified as early as possible in the newborn period.

MEASURE

The percent of newborns in the State with at least one screening for each of PKU, hypothyroidism, galactosemia, and hemoglobinopathies [(e.g., the sickle cell diseases) (combined)].

DEFINITION**Numerator:**

The number of occurrent births in the State receiving at least one screen for each of PKU, hypothyroidism, galactosemia, and hemoglobinopathies [(e.g., the sickle cell diseases) (combined)].

Denominator:

The number of occurrent births in the State.

Units: 100 **Text:** Percent

**HEALTHY PEOPLE 2010
OBJECTIVE**

Objective 16-20 (Developmental)

Ensure appropriate newborn bloodspot screening, follow-up testing, and referral to services.

Objective 16-20a

Ensure that all newborns are screened at birth for conditions mandated by their State-sponsored newborn screening programs, for example, phenylketonuria and hemoglobinopathies.

Related to Objective 16-20b

Ensure that follow up diagnostic testing for screening positives is performed within an appropriate time period.

DATA SOURCE and DATA ISSUES

State data system for newborn screening, CORN newborn screening annual report, and the birth registry. Potential data source: Title V Performance Measures, HRSA, MCHB National Newborn Screening and Genetic Resource Center.

SIGNIFICANCE

Newborn screening for PKU, hypothyroidism and galactosemia is one of the major public health success stories with a significant social and cost benefit. Preventable mental retardation, growth stunting and other illnesses are averted through early diagnosis and treatment of those with a confirmed diagnosis. It is crucial that the State's commitment to newborn screening is maintained and accompanied by a commitment for treatment and follow-up of diagnosed newborns.

PERFORMANCE MEASURE**Type:** Risk Factor**Category:** Population Based

Percent of children through age 2 who have completed immunizations for Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, Hepatitis B.

GOAL

To avert all cases of vaccine-preventable morbidity and mortality in children.

MEASURE

Percent of 19-35 month olds who have received the full schedule of age-appropriate immunizations against measles, mumps, rubella, polio, diphtheria, tetanus, pertussis, H. influenza, and hepatitis B.

DEFINITION**Numerator:**

Number of resident children who have received the complete immunization schedule for DTP/DTAP, OPV, measles, mumps, rubella (MMR), H. influenza, and hepatitis B before their second birthday.

Complete immunization status is generally considered to be:

- 4 DTaP
- 3 polio
- 1 MMR
- 3 Hib
- 3 Hepatitis B

Denominator:

Number of resident children aged 2 years

Units: 100 **Text:** Percent

**HEALTHY PEOPLE 2010
OBJECTIVE**

Objective 14-24:

Increase the proportion of young children who receive all vaccines that have been recommended for universal administration for at least 5 years. Increase the proportion of children aged 19 through 35 months who received all recommended vaccines to 80 percent. (Baseline: 73 percent in 1998).

DATA SOURCE and DATA ISSUES

State Immunization Registry, CDC National Immunization Survey, State vital records, and Bureau of Census population estimates.

SIGNIFICANCE

Infectious diseases remain important causes of preventable illness in the United States despite significant reductions in incidence in the past 100 years. Vaccines are among the safest and most effective preventive measures.

PERFORMANCE MEASURE**Type: Risk Factor****Category: Population Based****The rate of birth (per 1,000) for teenagers aged 15 through 17 years.****GOAL**

To lower the birth rate among teenagers, especially those aged 15 through 17 years.

MEASURE

The birth rate (per 1,000) for teenagers aged 15 through 17 years at the time of delivery.

DEFINITION**Numerator:**

Number of live births to teenagers aged 15-17 years in the calendar year.

Denominator:

Number of females aged 15 through 17 years in the calendar year.

Units: 1000 **Text:** Rate per 1,000

**HEALTHY PEOPLE 2010
OBJECTIVE**

Objective 9-7

Reduce pregnancies among females aged 15-17 to no more than 46 per 1,000 females aged 15-17 years. (Baseline: 72 pregnancies per 1,000 females aged 15-17 years in 1995).

DATA SOURCE and DATA ISSUES

Vital records are the source of data on mother's age and births. Population numbers are available from the Census.

SIGNIFICANCE

DHHS is making lowering the rate of teen pregnancies (a major threat to healthy and productive lives) a priority goal in its strategic plan. Teen parenting is associated with the lack of high school completion and initiating a cycle of poverty for mothers.

PERFORMANCE MEASURE**Type: Risk Factor****Category: Population Based****Percent of third grade children who have received protective sealants on at least one permanent molar tooth.****GOAL**

To prevent pit and fissure tooth decay (dental caries).

MEASURE

Percent of third grade children who have one or more sealed permanent molar teeth.

DEFINITION**Numerator:**

Number of third grade children who have a protective sealant on at least one permanent molar tooth.

Denominator:

Number of third grade children in the State during the year.

Units: 100 **Text:** Percent**HEALTHY PEOPLE 2010
OBJECTIVE**

Objective 21-8

Increase the proportion of children who have received dental sealants on their molar teeth to 50 percent. (Baseline: 23 percent of children aged 8 years received sealants on their molars in the years 1988-94.

DATA SOURCE and DATA ISSUES

This requires primary data collection, such as examination or screening of a representative sample of school children.

SIGNIFICANCE

Dental caries affects two-thirds of children by the time they are 15 years of age. Developmental irregularities, called pits and fissures, are the sites of 80-90% of childhood caries. Sealants selectively protect these vulnerable sites, which are found mostly in permanent molar teeth. Targeting sealants to those at greatest risk for caries has been shown to increase their cost-effectiveness. Although sealants have the potential to combine with fluorides to prevent almost all childhood tooth decay, they have been underutilized.

In addition to being an excellent service in preventing tooth decay, sealants may also be a surrogate indicator of dental access, oral health promotion and preventive activities, and a suitable means to assess the linkages that exist between the public and private services delivery system. Public managed sealant programs are usually school-based or school-linked and target under served children, thus providing entry to other services. It has been stated on several occasions that dental sealants are the

PERFORMANCE MEASURE**Type: Risk Factor****Category: Population Based****The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.****GOAL**

To reduce the number of deaths to children aged 14 years and younger caused by motor vehicle crashes.

MEASURE

The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children aged 14 years and younger.

DEFINITION**Numerator:**

Number of deaths to children aged 14 years and younger caused by motor vehicle crashes. This includes all occupant, pedestrian, motorcycle, bicycle, etc. deaths caused by motor vehicles.

Denominator:

All children in the State aged 14 years and younger.

Units: 100,000 **Text:** Rate per 100,000

**HEALTHY PEOPLE 2010
OBJECTIVE**

Objective 15-15

Reduce deaths caused by motor vehicle crashes to 9.0 deaths per 100,000 population. (Baseline: 15 deaths per 100,000 population caused by motor vehicle crashes in 1998. Baseline for children aged 14 years and under, 4.2 deaths per 100,000 in 1998).

DATA SOURCE and DATA ISSUES

Fatal Accident Reporting System (FARS), U.S. Department of Transportation, and Vital Statistics Systems are sources of the data.

SIGNIFICANCE

About 50% of all deaths to children aged 14 years and younger are due to injuries, and around 80% of these are from motor vehicle crashes. Injuries are the leading cause of mortality in this age group and they are one of the most significant health problems affecting the Nation's children.

PERFORMANCE MEASURE**Type: Risk Factor****Category: Population Based****Percentage of mothers who breastfeed their infants at hospital discharge.****GOAL**

To increase the percentage of mothers who breastfeed their infants at hospital discharge.

MEASURE

Percent of mothers in the State who breastfeed their infants at hospital discharge.

DEFINITION**Numerator:**

The number of mothers in the State who exclusively* breastfeed their infant at hospital discharge.

Denominator:

Number of occurrent births in the State in the calendar year.

Units: 100 **Text:** Percent**HEALTHY PEOPLE 2010
OBJECTIVE**

Objective 16-19a

Increase the proportion of mothers who breast feed their babies in the early postpartum period to 75 percent. (Baseline: 64 percent in 1998)

DATA SOURCE and DATA ISSUES

Ross Laboratories Mothers Survey; State WIC data, USDA; State Pediatric Nutrition Surveillance System, CDC.

SIGNIFICANCE

The advantages of breastfeeding are indisputable and include nutritional, immunological and psychological benefits to both infant and mother, as well as economic benefits.

*Exclusively is defined as vitamins, minerals, water, juice, cultural foods given infrequently in addition to breastfeeds.

Source: Labbok and Krasovec, "Toward Consistency in Breastfeeding Definitions" in *Studies in Family Planning* 1990; 21, 4:226-230

PERFORMANCE MEASURE**Type: Risk Factor****Category: Population Based****Percentage of newborns who have been screened for hearing impairment before hospital discharge.****GOAL**

To reduce the morbidity associated with hearing impairment through early detection.

MEASURE

Percent of newborns screened for hearing impairment before hospital discharge.

DEFINITION**Numerator:**

The number of infants in the State whose hearing has been screened before hospital discharge by tests of either otoacoustic emissions or auditory brainstem responses.

Denominator:

Number of births in the State in the calendar year.

Units: 100 **Text:** Percent**HEALTHY PEOPLE 2010
OBJECTIVE**

Objective 28-11

Increase the proportion of newborns who are screened for hearing loss by age 1 month, have audiologic evaluation by age 3 months, and are enrolled in appropriate intervention services by age 6 months.

DATA SOURCE and DATA ISSUESState birth certificates, newborn hearing registries, tests of otoacoustic emissions and auditory brainstem responses.
Potential data source - State based Early Hearing Detection and Intervention (EHDI) Program Network, CDC.**SIGNIFICANCE**

The advantages of early detection of hearing impairments are indisputable and include necessary follow-up of free and appropriate enrollment in habilitation and education programs.

*Hearing impairment covers the range of hearing deficits from mild loss in one ear to profound loss in both ears. Generally, inability to hear sounds at levels softer (less intense) than 20 decibels (dB) constitutes abnormal hearing. Significant hearing impairment is defined as having hearing thresholds for speech poorer than 25 dB. However, impairment (that is, deafness in one or both ears or any trouble hearing in one or both ears) will be used as a proxy measure for significant hearing impairment.

-Disabilities and Chronic Disabling Conditions Objectives, *Healthy People 2000 Review*, 1997, p. 163.

PERFORMANCE MEASURE**Type:** Capacity**Category:** Infrastructure Building**Percent of Children with Special Health Care Needs (CSHCN) in the State CSHCN program with a source of insurance for primary and specialty care****GOAL**

To assure a source of insurance, including Medicaid, for primary and specialty care required to meet the needs of Children with Special Health Care Needs (CSHCN).

MEASURE

Percentage of CSHCN in the State CSHCN program who have a source of insurance, including Medicaid, for primary care, specialty care, and enabling services.

DEFINITION**Numerator:**

The number of CSHCN in the State CSHCN program who have a source of insurance, including Medicaid, to cover the costs of primary, specialty, and enabling services during the reporting period. This may be measured by valid sampling techniques.

Denominator:

The number of CSHCN covered by the State program.

Units: 100 **Text:** Percent

**HEALTHY PEOPLE 2010
OBJECTIVE**

Related to Objective 1-1

Increase the proportion of persons with health insurance to 100 percent. (Baseline: 86 percent of the population was covered by health insurance in 1997).

Related to Objective 16-22 (Developmental)

Increase the proportion of CSHCN who have access to a medical home.

Related to Objective 16-23

Increase the proportion of Territories and States that have service systems for Children with Special Health Care Needs to 100 percent. (Baseline: 15.7 percent of Territories and States met Title V for service systems for CSHCN in FY 1997).

DATA SOURCE and DATA ISSUES

The State CSHCN program.

SIGNIFICANCE

CSHCN are disproportionately low-income, and because of this, they are at higher risk for being uninsured. Moreover, because their needs for health services extend beyond those required by healthy children, they are more likely to incur catastrophic expenses. Since children are more likely to obtain health care if they are insured, this measure is an important indicator of access to care.

PERFORMANCE MEASURE**Type:** Capacity**Category:** Infrastructure Building**Percent of children without health insurance.**

GOAL

To ensure access to needed and continuous health care services for children.

MEASURE

Percent of children without health insurance.

DEFINITION**Numerator:**

Number of children under 18 in the State who are not covered by any private or public health insurance (including Medicaid or risk pools) at some time during the reporting year.

Denominator:

Number of children in the State under 18 (estimated by Census in March).

Units: 100 **Text:** Percent

**HEALTHY PEOPLE 2010
OBJECTIVE**

Related to Objectives: 1-1

Increase the proportion of persons with health insurance to 100 percent. (Baseline: 86 percent of the population was covered by health insurance in 1997).

DATA SOURCE and DATA ISSUES

There is no current uniform source of data at the State level, but data may be available by State estimate beginning in 1997 from the March CPS, U.S. Bureau of the Census. States need to choose among existing estimating techniques and use one consistently.

SIGNIFICANCE

There is a well-documented association between insurance status and utilization of health care services among adults. Less is known about the utilization of services in children. A 1996 study by the Harvard School of Public Health, The Henry J. Kaiser Foundation and the National Opinion Research Center found the uninsured are four times more likely to have an episode of needing and not getting medical care. As noted in the 1997 "Families USA Report", children without health insurance have an average of 1 less visit per year and receive less treatment than insured children with similar problems.

PERFORMANCE MEASURE**Type: Process****Category: Infrastructure Building****Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program****GOAL**

To enroll all Medicaid eligible children in Medicaid ensuring better access to health care services.

MEASURE

Percent of potentially Medicaid eligible children who have received a paid Medicaid service.

DEFINITION**Numerator:**

Number of children 1 to 21 years of age who have received a service paid by Medicaid during the federal fiscal year.

Denominator:

The estimated number of children 1 to 21 years of age who are potentially eligible, by State definition, for Medicaid at the end of the federal fiscal year.

Units: 100 **Text:** Percent

**HEALTHY PEOPLE 2010
OBJECTIVE**

Related to Objective 1-4b

Increase the proportion of children and youth aged 17 years and under who have a specific source of ongoing care to 96 percent. (Baseline: 93 percent in 1997).

Related to Objective 1-6

Reduce the proportion of families that experience difficulties or delays in obtaining health care or do not receive needed care for one or more family members to 7 percent. (Baseline: 12 percent in 1996).

DATA SOURCE and DATA ISSUES

Numerator: The State Medicaid program counts participation monthly and estimates annual caseload. There are peaks and valleys in participation throughout the year. Most systems do not link the income of the family on the program records, but only the eligibility category (e.g., AFDC, expansion, etc.).

Denominator: States may not have these data readily available and therefore estimates are made by using a variety of data from CPS, State programs, Census, and experience.

SIGNIFICANCE

Financial access to health care does not guarantee that all children will enroll and access care, but insured children are more likely to get care. Currently 3 million children are estimated to be eligible non-participants in Medicaid.

PERFORMANCE MEASURE**Type: Process****Category: Infrastructure Building****The degree to which the State assures family participation in program and policy activities in the State CSHCN program.****GOAL**

To ensure family participation in program and policy activities in the State CSHCN program.

MEASURE

The State assures family participation in program and policy activities in the State CSHCN program.

DEFINITION

Attached is a checklist of six characteristics that document family participation. Please check the degree to which the characteristics for the State CSHCN program have been implemented. The answer is 0-18. Please keep the completed checklist attached.

Numerator:

none

Denominator:

none

Units: 0-18 **Text:** Scale**HEALTHY PEOPLE 2010
OBJECTIVE**

Related to Objective 16-23

Increase the proportion of Territories and States that have service systems for Children with Special Health Care Needs to 100 percent. (Baseline: 15.7 percent of Territories and States met Title V for service systems for CSHCN in FY 1997).

DATA SOURCE and DATA ISSUES

The State CSHCN program.

SIGNIFICANCE

The last decade has emphasized the central role of families as advisors and participants in policy-making activities. The Omnibus Budget Reconciliation Act of 1989 (OBRA '89) created the legislative mandate that health programs supported by Maternal and Child Health Bureau (MCHB) would provide and promote family-centered, community-based, coordinated care.

15

PERFORMANCE MEASURE

Type: Risk Factor

Category: Infrastructure Building

Percent of very low birth weight live births.

GOAL

To reduce the proportion of all live deliveries with very low birth weight.

MEASURE

The percent of very low birth weight infants among all live births.

DEFINITION

Numerator:

Number of live births with birth weight less than 1,500 grams in the calendar year.

Denominator:

Total number of live births in the calendar year.

Units: 100 **Text:** Percent

HEALTHY PEOPLE 2010 OBJECTIVE

Objective 16-10b

Reduce very low birth weights to 0.9 percent. (Baseline: 1.4 percent in 1997).

DATA SOURCE and DATA ISSUES

Birth certificates are the source for low birth weight.

SIGNIFICANCE

Prematurity is the leading cause of infant death. Many risk factors have been identified for low birth weight involving younger and older maternal age, poverty, late prenatal care, smoking and substance abuse.

PERFORMANCE MEASURE**Type: Risk Factor****Category: Infrastructure Building****The rate (per 100,000) of suicide deaths among youths aged 15 through 19.****GOAL**

To eliminate self-induced, preventable morbidity and mortality.

MEASURE

The rate (per 100,000) of suicide deaths to youths aged 15 through 19.

DEFINITION**Numerator:**

Number of deaths attributed to suicide among youths aged 15 through 19.

Denominator:

Number of youths aged 15 through 19.

Units: 100,000 **Text:** Rate per 100,000**HEALTHY PEOPLE 2010
OBJECTIVE**

Related to Objectives 18-1

Reduce the suicide rate to 6.0 deaths per 100,000 population. (Baseline: 10.8 suicide deaths per 100,000 in 1997).

Related to Objective 18-2

Reduce the rate of suicide attempts by adolescents in grades 9 through 12 to a 12 month average of 1 percent. (Baseline: 12 month average of 2.6 percent among adolescents in grades 9 through 12 in 1997).

DATA SOURCE and DATA ISSUES

State vital records is the source.

SIGNIFICANCE

Suicide is the third leading cause of death in the United States among youths aged 15-19, and in many States it ranks as the second leading cause of death in this population.

PERFORMANCE MEASURE**Type: Risk Factor****Category: Infrastructure Building****Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.****GOAL**

To assure that higher risk mothers and newborns deliver at appropriate level hospitals.

MEASURE

Percentage of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.*

DEFINITION**Numerator:**

Number of infants with a birth weight less than 1,500 grams born at sub-specialty facilities (Level III facility).

Denominator:

Total number of infants born with a birth weight of less than 1,500 grams.

Units: 100 **Text:** Percent

**HEALTHY PEOPLE 2010
OBJECTIVE**

Objective 16-8

Increase the proportion of very low birth weight (VLBW) infants born at level III hospitals or sub-specialty perinatal centers to 90 percent. (Baseline: 73 percent of VLBW born at level III hospitals or sub-specialty perinatal centers in the years 1996-97).

DATA SOURCE and DATA ISSUES

There is no national data source for this at present. Vital records and hospital discharge records would be sources.

SIGNIFICANCE

Very low birth weight infants are more likely to survive and thrive if they are born/cared for in an appropriately staffed and equipped facility with a high volume of high risk admissions.

*Note: Level III facilities were originally developed by the National Foundation March of Dimes in the first edition of *Improving the Outcome of Pregnancy*. The new edition of *Improving the Outcome of Pregnancy*, and the 4th edition of ACOG/AAP's *Guidelines for Perinatal Care* (Summer 1997) classify facilities as basic, specialty and sub-specialty. The latter corresponds with Level III facilities and practitioner competencies. Although there is no universally applied scoring level for a high-risk pregnancy, the 4th edition of *Guidelines* identifies some medical criteria for referral to the sub-specialty center (e.g., women with severe pulmonary disease). Infants <1500 grams or <32 weeks should be delivered at or transferred to a sub-specialty center (Level III). In addition, women with IUGR, placenta previa, polyhydramnios and those needing immediate complex care should be transferred to deliver at a sub-specialty center.

PERFORMANCE MEASURE**Type: Risk Factor****Category: Infrastructure Building****Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.****GOAL**

To assure early entrance into prenatal care to enhance pregnancy outcomes.

MEASURE

Percent of infants born to pregnant women initiating prenatal care in the first trimester of pregnancy.

DEFINITION**Numerator:**

Number of live births with reported first prenatal visit during the first trimester (before 13 weeks' gestation) in the calendar year.

Denominator:

Number of live births in the State in the calendar year.

Units: 100 **Text:** Percent

**HEALTHY PEOPLE 2010
OBJECTIVE**

Objective 16-6a

Increase the proportion of pregnant women who receive early and adequate perinatal care beginning in the first trimester of pregnancy to 90 percent. (Baseline: 83 percent in 1998).

DATA SOURCE and DATA ISSUES

Birth certificate data in the State vital records are available for over 99% of births.

SIGNIFICANCE

Early identification of maternal disease and risks for complications of pregnancy or birth are the primary reason for first trimester entry into prenatal care. This can help ensure that women with complex problems and women with chronic illness or other risks are seen by specialists. Early high-quality prenatal care is critical to improving pregnancy outcomes.

01

OUTCOME MEASURE

Type: Outcome

Category: N/A

The infant mortality rate per 1,000 live births.

GOAL

To reduce the number of infant deaths.

MEASURE

Infant (from birth to 364 days) deaths per 1,000 live births.

DEFINITION

Numerator:

Number of deaths to infants from birth through 364 days of age.

Denominator:

Number of live births.

Units: 1,000 **Text:** Rate per 1,000

HEALTHY PEOPLE 2010 OBJECTIVE

Objective 16-1c

Reduction of infant deaths (within 1 year) to 4.5 per 1,000 live births.
(Baseline: 7.2 in 1998).

DATA SOURCE and DATA ISSUES

Vital records collected by the State.

SIGNIFICANCE

All countries of the world measure the infant mortality rate as an indicator of general health status. The U.S. has made progress in reducing this rate, but the rate of decline has slowed in the last 10 years. There is still significant racial disparity, as noted in the Healthy People 2000 Mid-course Review. Rates are much higher in the lower social class and in the lowest income groups across all populations.

OUTCOME MEASURE**Type: Outcome****Category: N/A****The ratio of the black infant mortality rate to the white infant mortality rate.****GOAL**

To reduce the disparity (ratio) between the black and white infant mortality rates.

MEASURE

The ratio of the black infant mortality rate to the white infant mortality rate.

DEFINITION**Numerator:**

The black infant mortality rate per 1,000 live births.

Denominator:

The white infant mortality rate per 1,000 live births.

Units: 1 **Text:** Ratio

**HEALTHY PEOPLE 2010
OBJECTIVE**

Objectives 16-1c

Reduce all infant deaths (within 1 year) to 4.5 per 1,000 live births.

Objective 16-1d

Reduce all neonatal deaths (within the first 28 days of life) to 2.9 per 1,000 live births.

Objective 16-1e

Reduce all postneonatal deaths (between 28 days and 1 year) to 1.5 per 1,000 live births. (Baselines [all 1997] - Infant deaths: White = 6.0 and Black = 13.7; Neonatal deaths: White = 4.0 and Black = 9.2; Postneotatal deaths: White = 2.1 and Black = 4.5).

DATA SOURCE and DATA ISSUES

Vital records collected by the State.

SIGNIFICANCE

All countries of the world measure the infant mortality rate as an indicator of general health status. The U.S. has made progress in reducing this rate, but the rate of decline has slowed in the last 10 years. There is still significant racial disparity, as noted in the Healthy People 2000 Mid-course Review. Rates are much higher in the lower social class and in the lowest income groups across all populations. The disparity (ratio) for Black infant mortality is over twice the White rate. Black women are twice as likely as White women to experience prematurity, low birth weight, and fetal death.

03

OUTCOME MEASURE

Type: Outcome

Category: N/A

The neonatal mortality rate per 1,000 live births.

GOAL

To reduce the number of neonatal deaths.

MEASURE

The neonatal death rate (deaths to infants under 28 days) per 1,000 live births.

DEFINITION

Numerator:

Number of deaths to infants under 28 days.

Denominator:

Number of live births.

Units: 1000 **Text:** Rate per 1000

HEALTHY PEOPLE 2010 OBJECTIVE

Objective 16-1d

Reduce all neonatal deaths (within the first 28 days of life) to 2.9 per 1,000 live births. (Baseline: 4.8 in 1998).

DATA SOURCE and DATA ISSUES

Vital records collected by the State.

SIGNIFICANCE

Neonatal mortality is a reflection of the health of the newborn and reflects health status and treatment of the pregnant mother and of the baby after birth.

04

OUTCOME MEASURE

Type: Outcome

Category: N/A

The postneonatal mortality rate per 1,000 live births.

GOAL

To reduce the number of postneonatal deaths.

MEASURE

Postneonatal (28 to 364 days) deaths per 1,000 live births.

DEFINITION

Numerator:

Number of deaths to infants 28 through 364 days of age.

Denominator:

Number of live births.

Units: 1000 **Text:** Rate per 1000

HEALTHY PEOPLE 2010 OBJECTIVE

Objective 16-1e

Reduce all post-neonatal deaths (between 28 days and 1 year) to 1.5 per 1,000 live births. (Baseline: 2.4 in 1998).

DATA SOURCE and DATA ISSUES

Vital records collected by the State.

SIGNIFICANCE

This period of mortality reflects the environment and the care infants receive. SIDS deaths occur during this period and have been recently reduced due to new infant positioning in the U.S. Poverty and a lack of access to timely care are also related to late infant deaths.

05

OUTCOME MEASURE

Type: Outcome

Category: N/A

The perinatal mortality rate per 1,000 live births plus fetal deaths.

GOAL

To reduce the number of perinatal deaths.

MEASURE

Perinatal deaths (neonatal deaths under 7 days and fetal deaths of \geq 28 weeks' gestation) per 1,000 live births.

DEFINITION

Numerator:

Number of fetal deaths \geq 28 weeks' gestation plus deaths occurring under 7 days.

Denominator:

Live births + fetal deaths.

Units: 1,000 **Text:** Rate per 1,000

HEALTHY PEOPLE 2010 OBJECTIVE

Objective 16-1b

Reduce the death rate during the perinatal period (28 weeks of gestation to 7 days or less after birth) to 4.5 per 1,000 live births plus fetal deaths. (Baseline: 7.5 in 1997).

DATA SOURCE and DATA ISSUES

Vital records collected by the State.

SIGNIFICANCE

Perinatal mortality is a reflection of the health of the pregnant woman and newborn and reflects the pregnancy environment and early newborn care.

OUTCOME MEASURE**Type: Outcome****Category: N/A****The child death rate per 100,000 children aged 1 through 14.****GOAL**

To reduce the death rate of children aged 1 through 14.

MEASURE

Child death rate for 1 through 14 year olds per 100,000 children in that age range.

DEFINITION**Numerator:**

Number of deaths among children aged 1 through 14 years.

Denominator:

Number of children aged 1 through 14.

Units: 100,000 **Text:** Rate per 100,000**HEALTHY PEOPLE 2010
OBJECTIVE**

Combination of Objective 16-2a, Objective 16-2b, Objective 16-3a

Objective 16-2a

Reduce deaths in children aged 1 to 4 years to 25.0 per 100,000 in that age group. (Baseline: 34.2 in 1998).

Objective 16-2b

Reduce deaths in children aged 5 to 9 years to 14.3 per 100,000 in that age group. (Baseline: 17.6 in 1998).

Objective 16-3a

Reduce deaths in adolescents aged 10 to 14 years to 16.8 per 100,000 in that age group. (Baseline: 21.8 in 1998).

DATA SOURCE and DATA ISSUES

Child death certificates are collected by State vital records. Data on total number of children comes from the Census.

SIGNIFICANCE

While children's likelihood of survival increases dramatically after the first year of life, the child death rate remains of concern. The child death rate has decreased in the last decade, falling from 33.8 in 1985 to 28.8 in 1992. The DHHS's strategic plan identifies improvements in the rates of preventable death as part of priority goals for children and youth.